

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN0504</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>FOOTHILLS TRANSITIONAL CARE AND REHA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1012 JAMESTOWN WAY</b> <b>MARYVILLE, TN 37803</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  Investigation of complaint #50669 was conducted on 3/16/2020 at Foothills Transitional Care and Rehabilitation. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE